***State:*** *Arkansas* ***Filing Company:*** *Colorado Bankers Life Insurance Company*
***TOI/Sub-TOI:*** *L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
***Product Name:*** *MIB Revisions - Mountain Vista Application*
***Project Name/Number:*** */*

# Filing at a Glance

| | |
|---|---|
| Company: | Colorado Bankers Life Insurance Company |
| Product Name: | MIB Revisions - Mountain Vista Application |
| State: | Arkansas |
| TOI: | L04I Individual Life - Term |
| Sub-TOI: | L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life |
| Filing Type: | Form |
| Date Submitted: | 12/27/2012 |
| SERFF Tr Num: | FDLB-128826676 |
| SERFF Status: | Closed-Approved-Closed |
| State Tr Num: | |
| State Status: | Approved-Closed |
| Co Tr Num: | |
| Implementation Date Requested: | On Approval |
| Author(s): | Howard Moy |
| Reviewer(s): | Linda Bird (primary) |
| Disposition Date: | 01/04/2013 |
| Disposition Status: | Approved-Closed |
| Implementation Date: | |

State Filing Description:

**State:** *Arkansas* **Filing Company:** *Colorado Bankers Life Insurance Company*
**TOI/Sub-TOI:** *L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
**Product Name:** *MIB Revisions - Mountain Vista Application*
**Project Name/Number:** */*

## General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Howard Moy

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: Filing not required in CO
Market Type: Individual
Individual Market Type:
Filing Status Changed: 01/04/2013
State Status Changed: 01/04/2013
Created By: Howard Moy
Corresponding Filing Tracking Number:

Filing Description:

To Be Filed:
FORM NUMBER DESCRIPTION
A-Term 2010 REV12-12 Individual Life Insurance Application

Replaces:
FORM NUMBER DATE PREVIOUSLY APPROVED FILE NUMBER
A-Term 2010 11/23/2010 FDLB-126904559

Dear Reviewer,

On behalf of our subsidiary, Colorado Bankers Life Insurance Company (CBL), we are submitting the above application listed under “To Be Filed.” This application replaces the application listed under “Replaces.”

The new form differs from its prior version by the insertion of verbiage requested by the Medical Information Bureau (MIB) in section 8G of the form. For ease of review, we have highlighted the revised wording (in green) in addition to providing copies of the form in its final format (without highlights).

The final form is subject only to changes in formatting (font style, margins, page numbers, ink and paper stock) and correcting typographical errors. Printing standards will not be lower than those required under the laws of your State.

In addition to the captioned form, we have included an authorization letter signed by an officer of CBL for this filing.

We hope that all is in order with this filing. If you have questions or comments regarding this matter, please do not hesitate to contact me.

Yours truly,
Howard Moy

## Company and Contact

### Filing Contact Information

Howard Moy,
1020 31st Street
Downers Grove, IL 60135

howard_moy@dearbornnational.com
630-824-6702 [Phone]

***State:*** *Arkansas* ***Filing Company:*** *Colorado Bankers Life Insurance Company*
***TOI/Sub-TOI:*** *L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
***Product Name:*** *MIB Revisions - Mountain Vista Application*
***Project Name/Number:*** */*

### Filing Company Information

Colorado Bankers Life Insurance Company
5990 Greenwood Plaza Blvd., #325
Greenwood Village, CO 80111
(303) 220-8500 ext. [Phone]

CoCode: 84786
Group Code: 917
Group Name:
FEIN Number: 84-0674027

State of Domicile: Colorado
Company Type: Life and Health
State ID Number:

## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $50.00 |
| Retaliatory? | No |
| Fee Explanation: | 1 form @ $50 |
| Per Company: | No |

| Company | Amount | Date Processed | Transaction # |
|---|---|---|---|
| Colorado Bankers Life Insurance Company | $50.00 | 12/27/2012 | 66042101 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *FDLB-128826676* | ***State Tracking #:*** | | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Colorado Bankers Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* | | |
| ***Product Name:*** | *MIB Revisions - Mountain Vista Application* | | |
| ***Project Name/Number:*** | */* | | |

# Correspondence Summary

## Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Linda Bird | 01/04/2013 | 01/04/2013 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *FDLB-128826676* | ***State Tracking #:*** | | ***Company Tracking #:*** | |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Colorado Bankers Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* | | |
| ***Product Name:*** | *MIB Revisions - Mountain Vista Application* | | |
| ***Project Name/Number:*** | */* | | |

## Disposition

Disposition Date: 01/04/2013
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | | No |
| **Supporting Document** | Application | | No |
| **Supporting Document** | Life & Annuity - Acturial Memo | | No |
| **Supporting Document** | "Redline" version | | No |
| **Supporting Document** | Authorization letter | | No |
| **Form** | Individual Term Life Application | | No |

**SERFF Tracking #:** FDLB-128826676 **State Tracking #:** **Company Tracking #:**

**State:** Arkansas **Filing Company:** Colorado Bankers Life Insurance Company
**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
**Product Name:** MIB Revisions - Mountain Vista Application
**Project Name/Number:** /

# Form Schedule

**Lead Form Number:**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| 1 | | Individual Term Life Application | A-Term 2010 REV 12-12 | AEF | Initial | | | A-Term 2010 REV12-12 final.pdf |

**Form Type Legend:**

| | | | |
|---|---|---|---|
| **ADV** | Advertising | **AEF** | Application/Enrollment Form |
| **CER** | Certificate | **CERA** | Certificate Amendment, Insert Page, Endorsement or Rider |
| **DDP** | Data/Declaration Pages | **FND** | Funding Agreement (Annuity, Individual and Group) |
| **MTX** | Matrix | **NOC** | Notice of Coverage |
| **OTH** | Other | **OUT** | Outline of Coverage |
| **PJK** | Policy Jacket | **POL** | Policy/Contract/Fraternal Certificate |
| **POLA** | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | **SCH** | Schedule Pages |

Dearborn National

# Mountain Vista® Individual Life Insurance Application

Underwritten by **COLORADO BANKERS LIFE INSURANCE COMPANY®**
**[5990 Greenwood Plaza Blvd. • Greenwood Village, Colorado 80111]**

## 1. PROPOSED INSURED AND BENEFICIARY INFORMATION

| Last Name | First Name | MI | Phone Number for Contact |
|---|---|---|---|
| | | | Day Phone:<br>Evening Phone:<br>Best Time To Call: |

| Social Security Number | Age | Sex | Date of Birth | State of Birth | Height | Weight |
|---|---|---|---|---|---|---|
| | | | | | | |

| Primary Street Address | City | County | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Email | Occupation | Length of Current Employment | Annual Salary |
|---|---|---|---|
| | | _____Years _____Months | $_____ |

Is the Proposed Insured currently working or employed at least 30 hours per week at a regular occupation or business? ☐ Yes ☐ No
If not, please attach separate page with explanation.

Secondary Addressee Option. Provide name and complete address. *Under this option, we will send the Secondary Addressee a notice of the lapse of this insurance due to non-payment of the premium.*

| **Primary Beneficiary** – Name/Relationship | **Contingent Beneficiary** – Name/Relationship |
|---|---|
| | |
| **Spouse Term Rider Beneficiary** – Name/Relationship | **Spouse Term Rider Contingent Beneficiary** – Name/Relationship |
| | |

## 2. OWNER (If Other than Proposed Insured)

| Last Name | First Name | MI | Tax ID# or Social Security # |
|---|---|---|---|
| | | | |

| Primary Street Address | City | County | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Relationship to Proposed Insured | Email |
|---|---|
| | |

## 3. INSURANCE APPLIED FOR

Level Premium Period: ☐10 Years ☐20 Years ☐30 Years Face Amount $_____

## 4. RIDERS (Not Available In All States)

**Spouse Term Rider (covering the Insured Spouse):** ☐[$10,000] ☐[$20,000] ☐[$25,000] ☐[$50,000] ☐**Waiver of Premium Rider**

**Child Term Rider (covering each Insured Child):** ☐[$5,000] ☐[$10,000]

| | Name | Sex | Date of Birth | Social Security Number | Height | Weight |
|---|---|---|---|---|---|---|
| **Insured Spouse:** | | | / / | - - | | |
| **Insured Child:** | | | / / | - - | | |
| **Insured Child:** | | | / / | - - | | |

***If additional insured children, attach separate page to application with name, sex, date of birth, and Social Security number.***

## 5. PREMIUM AND BILLING INFORMATION

Premium..... $_____ Payment With Application.....$_____

Premium Mode: **Direct Billing** ☐ Quarterly ☐ Semi-Annual ☐ Annual

**Other Billing** – Must complete a separate payment authorization

☐ Monthly EFT ☐ Payroll Deduction ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

## 6. HEALTH INFORMATION (Circle any condition which applies and for any "YES" answer give complete details in Section 6, Part II)

| **Part I:** ***Insured Spouse must answer health questions only if Spouse Term Rider is being applied for.*** | **Proposed Insured** | **Insured Spouse** |
|---|---|---|
| 1. Has the person to be insured ever been diagnosed, treated for, or taken medication for: | | |
| a) Emphysema, Pulmonary Fibrosis, Asthma, COPD (chronic obstructive pulmonary disease), or any other lung or respiratory disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) Hepatitis, Cirrhosis, other liver or kidney disorder, Sickle Cell Anemia, Lupus, or Sarcoidosis? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c) High Blood Pressure, Diabetes, or Elevated Cholesterol? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d) Heart Attack, Heart Surgery, Stroke, Aneurysm, Angina, or any other heart or circulatory disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e) Cerebral Palsy, Muscular Dystrophy (MD), Down Syndrome, Multiple Sclerosis (MS), a seizure disorder, or any other neurological disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f) Internal Cancer, Malignant Melanoma, Leukemia, or Hodgkin's Lymphoma? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Has the person to be insured ever received a tissue, organ, or bone marrow transplant? | ☐ Yes ☐ No | ☐ Yes ☐ No |

3. Has the person to be insured ever been diagnosed, treated for, or been told they will require treatment for a disorder of the Immune System including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other AIDS-related condition, or had a positive test for the AIDS virus Human Immunodeficiency Virus (HIV)? . . . ☐ Yes ☐ No ☐ Yes ☐ No

## 6. HEALTH INFORMATION (Circle any condition which applies and for any "YES" answer give complete details in Section 6, Part II)

| | | Proposed Insured | Insured Spouse |
|---|---|---|---|
| 4. | In the past 5 years has the person to be isnured had, been treated, or received counseling (court ordered or voluntary) for: Alcohol, Drug Abuse or Addiction? | □ Yes □ No | □ Yes □ No |
| 5. | Does the person to be insured have any chronic illness or condition which requires periodic medical care or medication, or for which future surgery is currently scheduled or recommended? | □ Yes □ No | □ Yes □ No |
| 6. | In the past 5 years has the person to be insured been hospitalized, consulted a physician, or received treatment for any illness or injury not disclosed in the answers already given? | □ Yes □ No | □ Yes □ No |
| 7. | Is the person to be insured currently taking or been advised to take any medication prescribed by a physician, surgeon or other practitioner (including psychologist, counselor, dentist, etc), not disclosed in the answers already given? | □ Yes □ No | □ Yes □ No |
| 8. | Has the person to be insured used: cigarettes, cigars, pipes, chewing tobacco, nicotine chewing gum, or other products containing nicotine within the last 12 months? | □ Yes □ No | □ Yes □ No |

**Part II:** *If additional space is needed to give details for any question, please state the information on a separate page, giving all the categories of information that are requested below, and the Proposed Insured and/or Insured Spouse to whom such information relates, should sign that separate page.*

| Q# | Person to be Insured | Nature of Condition | Date and Duration | Medication | Name of Doctor, Hospital or Facility | Address and Telephone Number |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## 7. REPLACEMENT INFORMATION

Do you have any existing life insurance or annuity coverage with Colorado Bankers Life Insurance Company ("CBL") or any other company? □ Yes □ No

If yes, is this insurance intended to replace or change any of that existing life insurance or annuity coverage? □ Yes □ No □ N/A

## 8. GENERAL INFORMATION

(A) **I (we) state** that the information given in this application, and any supplement to it, is true to the best of my (our) knowledge and belief.
**I (we) agree** that this application will be the basis for and part of any insurance issued from it. No information about me (us) will be considered to have been given by me (us) to **CBL** unless it is stated in this application or any supplement to it.

(B) **I (we) understand** the insurance applied for will take effect on the application date; but, **CBL** will have no liability under this application unless and until it is approved by **CBL** and the first premium is paid or an authorization for its payment has been signed by the applicant while the health and other conditions affecting the insurability of the person to be insured are as described in this application. No change in amount, classification, plan of insurance, age at issue, or benefits will be effective unless agreed to in writing by the Applicant.

(C) **I (we) understand** that benefits may be denied during the first 2 years after the insurance applied for is issued if: (a) I (we) did not give true and complete information and answers in this application; or (b) the person to be insured's health, given in this application, changes before the first premium for the insurance applied for is paid or properly authorized.

(D) **I (we) understand** that the agent is not authorized to: (a) accept risks or pass on a person to be insured's qualifications for insurance; (b) make or change insurance contracts; or (c) waive any of **CBL**'s rights or requirements.

(E) **I (we) understand** that any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

(F) **I (we) acknowledge** receipt of the **Information Disclosure Notice** required by the Fair Credit Reporting Act.

(G) **AUTHORIZATION TO RELEASE INFORMATION. I (the person to be insured) authorize** any physician, medical practitioner, pharmacists, pharmacy benefits managers, health care clearing houses, hospital, clinic, nurses, records custodians, health maintenance organization, including Mayo, Kaiser Foundation, Veterans Administration or other medical or medically related facility, insurance company, MIB, Inc. or EMSI, or other organization, institute, or person that has any records or knowledge of me or my family, or our health, medical or pharmacy history or physical or mental condition, to give to Colorado Bankers Life Insurance Company, its reinsurers, agents, contractors, employees, representatives, affiliates, assigns, and EMSI, as necessary any such information including alcohol abuse treatment, drug abuse treatment, psychiatric histories, pharmacy prescriptions, HIV (AIDS virus) testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's and to testify as to such information. I understand I may revoke this authorization at any time, by requesting such action of **CBL** and/or the other party to whom such revocation is to apply, in writing, unless action has already been taken in reliance upon this authorization, or during a contestability period under applicable law. I also authorize **CBL**, or its reinsurers, to make a brief report of my Protected Health Information available to MIB, Inc. A photostatic copy of this authorization will be as valid as the original, and I, or my representative, can obtain a copy on request. I also understand that when my medical records are disclosed pursuant to the authorization the information contained in those records may become subject to further disclosure by **CBL**. In such case, the information may no longer be protected by the rules governing this authorization. This authorization is valid for twenty-four (24) months after the date it was signed.

_____ **(Applicant's Initials) I (Applicant/Owner) authorize CBL, if I have given my email address in this application,** to send **all** present and future notices regarding the insurance applied for, to me at that email address. I may revoke this authorization at any time by sending a written notice to **CBL** to do so.

DATED AT_____ THIS _____ DAY OF _____ , 20____ .
CITY STATE

_____ _____ _____
Applicant/Owner's Signature | Print Proposed Insured's Name | Proposed Insured's Signature (if different than Applicant)

_____
Insured Spouse's Signature (if not already given and Spouse Term Rider applied for)

| | | | |
|---|---|---|---|
| ***SERFF Tracking #:*** | *FDLB-128826676* | ***State Tracking #:*** | ***Company Tracking #:*** |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Colorado Bankers Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L04I Individual Life - Term/L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life* | | |
| ***Product Name:*** | *MIB Revisions - Mountain Vista Application* | | |
| ***Project Name/Number:*** | */* | | |

## Supporting Document Schedules

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Flesch Certification | | |
| Comments: | | | |
| Attachment(s): | | | |
| AR Compliance Certification.pdf | | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | "Redline" version | | |
| Comments: | This form highlights the MIB revisions. | | |
| Attachment(s): | | | |
| A-Term 2010 REV12-12 (filed portion only - generic for MIB) .pdf | | | |

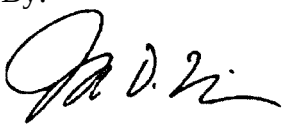
| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Authorization letter | | |
| Comments: | | | |
| Attachment(s): | | | |
| Auth ltr-MV.pdf | | | |

**COLORADO BANKERS LIFE INSURANCE COMPANY**

**CERTIFICATION OF COMPLIANCE**

I, Joseph D. Weiser, President of Colorado Bankers Life Insurance Company, hereby certify that, to the best of my knowledge, this submission meets the provisions of Rule & Regulation 19, Rule & Regulation 49, ACA 23-80-206 and ACA 23-79-138, as well as all applicable requirements of the Arkansas Department of Insurance.

By:



Joseph D. Weiser,
President,
Colorado Bankers Life Insurance Company

Date: December 27, 2012

Dearborn National

# Mountain Vista® Individual Life Insurance Application

Underwritten by **COLORADO BANKERS LIFE INSURANCE COMPANY®**
**[5990 Greenwood Plaza Blvd. • Greenwood Village, Colorado 80111]**

## 1. PROPOSED INSURED AND BENEFICIARY INFORMATION

| Last Name | First Name | MI | Phone Number for Contact |
|---|---|---|---|
| | | | Day Phone:<br>Evening Phone:<br>Best Time To Call: |

| Social Security Number | Age | Sex | Date of Birth | State of Birth | Height | Weight |
|---|---|---|---|---|---|---|
| | | | | | | |

| Primary Street Address | City | County | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Email | Occupation | Length of Current Employment | Annual Salary |
|---|---|---|---|
| | | _____Years _____Months | $_____ |

Is the Proposed Insured currently working or employed at least 30 hours per week at a regular occupation or business? ☐ Yes ☐ No
If not, please attach separate page with explanation.

Secondary Addressee Option. Provide name and complete address. *Under this option, we will send the Secondary Addressee a notice of the lapse of this insurance due to non-payment of the premium.*

| **Primary Beneficiary** – Name/Relationship | **Contingent Beneficiary** – Name/Relationship |
|---|---|
| | |
| **Spouse Term Rider Beneficiary** – Name/Relationship | **Spouse Term Rider Contingent Beneficiary** – Name/Relationship |
| | |

## 2. OWNER (If Other than Proposed Insured)

| Last Name | First Name | MI | Tax ID# or Social Security # |
|---|---|---|---|
| | | | |

| Primary Street Address | City | County | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Relationship to Proposed Insured | Email |
|---|---|
| | |

## 3. INSURANCE APPLIED FOR

Level Premium Period: ☐10 Years ☐20 Years ☐30 Years Face Amount $_____

## 4. RIDERS (Not Available In All States)

**Spouse Term Rider (covering the Insured Spouse):** ☐[$10,000] ☐[$20,000] ☐[$25,000] ☐[$50,000] ☐**Waiver of Premium Rider**

**Child Term Rider (covering each Insured Child):** ☐[$5,000] ☐[$10,000]

| | Name | Sex | Date of Birth | Social Security Number | Height | Weight |
|---|---|---|---|---|---|---|
| **Insured Spouse:** | | | / / | - - | | |
| **Insured Child:** | | | / / | - - | | |
| **Insured Child:** | | | / / | - - | | |

***If additional insured children, attach separate page to application with name, sex, date of birth, and Social Security number.***

## 5. PREMIUM AND BILLING INFORMATION

Premium..... $_____ Payment With Application.....$_____

Premium Mode: **Direct Billing** ☐ Quarterly ☐ Semi-Annual ☐ Annual

**Other Billing** – Must complete a separate payment authorization

☐ Monthly EFT ☐ Payroll Deduction ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

## 6. HEALTH INFORMATION (Circle any condition which applies and for any "YES" answer give complete details in Section 6, Part II)

| **Part I:** ***Insured Spouse must answer health questions only if Spouse Term Rider is being applied for.*** | **Proposed Insured** | **Insured Spouse** |
|---|---|---|
| 1. Has the person to be insured ever been diagnosed, treated for, or taken medication for: | | |
| a) Emphysema, Pulmonary Fibrosis, Asthma, COPD (chronic obstructive pulmonary disease), or any other lung or respiratory disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) Hepatitis, Cirrhosis, other liver or kidney disorder, Sickle Cell Anemia, Lupus, or Sarcoidosis? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c) High Blood Pressure, Diabetes, or Elevated Cholesterol? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d) Heart Attack, Heart Surgery, Stroke, Aneurysm, Angina, or any other heart or circulatory disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e) Cerebral Palsy, Muscular Dystrophy (MD), Down Syndrome, Multiple Sclerosis (MS), a seizure disorder, or any other neurological disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f) Internal Cancer, Malignant Melanoma, Leukemia, or Hodgkin's Lymphoma? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Has the person to be insured ever received a tissue, organ, or bone marrow transplant? | ☐ Yes ☐ No | ☐ Yes ☐ No |

3. Has the person to be insured ever been diagnosed, treated for, or been told they will require treatment for a disorder of the Immune System including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other AIDS-related condition, or had a positive test for the AIDS virus Human Immunodeficiency Virus (HIV)? . . . ☐ Yes ☐ No ☐ Yes ☐ No

## 6. HEALTH INFORMATION (Circle any condition which applies and for any "YES" answer give complete details in Section 6, Part II)

| | | Proposed Insured | Insured Spouse |
|---|---|---|---|
| 4. | In the past 5 years has the person to be isnured had, been treated, or received counseling (court ordered or voluntary) for: Alcohol, Drug Abuse or Addiction? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. | Does the person to be insured have any chronic illness or condition which requires periodic medical care or medication, or for which future surgery is currently scheduled or recommended? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. | In the past 5 years has the person to be insured been hospitalized, consulted a physician, or received treatment for any illness or injury not disclosed in the answers already given? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 7. | Is the person to be insured currently taking or been advised to take any medication prescribed by a physician, surgeon or other practitioner (including psychologist, counselor, dentist, etc), not disclosed in the answers already given? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 8. | Has the person to be insured used: cigarettes, cigars, pipes, chewing tobacco, nicotine chewing gum, or other products containing nicotine within the last 12 months? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**Part II:** *If additional space is needed to give details for any question, please state the information on a separate page, giving all the categories of information that are requested below, and the Proposed Insured and/or Insured Spouse to whom such information relates, should sign that separate page.*

| Q# | Person to be Insured | Nature of Condition | Date and Duration | Medication | Name of Doctor, Hospital or Facility | Address and Telephone Number |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## 7. REPLACEMENT INFORMATION

Do you have any existing life insurance or annuity coverage with Colorado Bankers Life Insurance Company ("CBL") or any other company? ☐ Yes ☐ No

If yes, is this insurance intended to replace or change any of that existing life insurance or annuity coverage? ☐ Yes ☐ No ☐ N/A

## 8. GENERAL INFORMATION

(A) **I (we) state** that the information given in this application, and any supplement to it, is true to the best of my (our) knowledge and belief.
**I (we) agree** that this application will be the basis for and part of any insurance issued from it. No information about me (us) will be considered to have been given by me (us) to **CBL** unless it is stated in this application or any supplement to it.

(B) **I (we) understand** the insurance applied for will take effect on the application date; but, **CBL** will have no liability under this application unless and until it is approved by **CBL** and the first premium is paid or an authorization for its payment has been signed by the applicant while the health and other conditions affecting the insurability of the person to be insured are as described in this application. No change in amount, classification, plan of insurance, age at issue, or benefits will be effective unless agreed to in writing by the Applicant.

(C) **I (we) understand** that benefits may be denied during the first 2 years after the insurance applied for is issued if: (a) I (we) did not give true and complete information and answers in this application; or (b) the person to be insured's health, given in this application, changes before the first premium for the insurance applied for is paid or properly authorized.

(D) **I (we) understand** that the agent is not authorized to: (a) accept risks or pass on a person to be insured's qualifications for insurance; (b) make or change insurance contracts; or (c) waive any of **CBL**'s rights or requirements.

(E) **I (we) understand** that any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

(F) **I (we) acknowledge** receipt of the **Information Disclosure Notice** required by the Fair Credit Reporting Act.

(G) **AUTHORIZATION TO RELEASE INFORMATION. I (the person to be insured) authorize** any physician, medical practitioner, pharmacists, pharmacy benefits managers, health care clearing houses, hospital, clinic, nurses, records custodians, health maintenance organization, including Mayo, Kaiser Foundation, Veterans Administration or other medical or medically related facility, insurance company, MIB, Inc. or EMSI, or other organization, institute, or person that has any records or knowledge of me or my family, or our health, medical or pharmacy history or physical or mental condition, to give to Colorado Bankers Life Insurance Company, its reinsurers, agents, contractors, employees, representatives, affiliates, assigns, and EMSI, as necessary any such information including alcohol abuse treatment, drug abuse treatment, psychiatric histories, pharmacy prescriptions, HIV (AIDS virus) testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's and to testify as to such information. I understand I may revoke this authorization at any time, by requesting such action of **CBL** and/or the other party to whom such revocation is to apply, in writing, unless action has already been taken in reliance upon this authorization, or during a contestability period under applicable law. I also authorize **CBL**, or its reinsurers, to make a brief report of my Protected Health Information available to MIB, Inc. A photostatic copy of this authorization will be as valid as the original, and I, or my representative, can obtain a copy on request. I also understand that when my medical records are disclosed pursuant to the authorization the information contained in those records may become subject to further disclosure by **CBL**. In such case, the information may no longer be protected by the rules governing this authorization. This authorization is valid for twenty-four (24) months after the date it was signed.

_____ **(Applicant's Initials) I (Applicant/Owner) authorize CBL, if I have given my email address in this application,** to send **all** present and future notices regarding the insurance applied for, to me at that email address. I may revoke this authorization at any time by sending a written notice to **CBL** to do so.

DATED AT_____ THIS _____ DAY OF _____ , 20____ .
CITY STATE

_____ _____ _____
Applicant/Owner's Signature | Print Proposed Insured's Name | Proposed Insured's Signature (if different than Applicant)

_____
Insured Spouse's Signature (if not already given and Spouse Term Rider applied for)

December 26, 2012

**Re:**
**Colorado Bankers Life Insurance Company**
**NAIC** #84786 - **FEIN** #84-0674027
MIB Revision for Individual Application "A-Term 2010 REV 12-12"

Dear Reviewer:

I authorize Dearborn National Life Insurance Company to file the captioned form(s) on behalf of Colorado Bankers Life Insurance Company.

Very truly yours,

Joseph D. Weiser
President,
Colorado Bankers Life Insurance Company

5990 Greenwood Plaza Boulevard, Greenwood Village, Colorado 80111
Toll Free: 800.367.7814 ▲ Fax: 303.220.8056 ▲ www.dearbornnational.com